**LifeSpan Family Services of PA**
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## Parent Health Assessment Statement

| | |
|---|---|
| Name: | |
| Date of Exam: | |

Foster Parent applicants are responsible for obtaining a medical health appraisal prior to being approved. Every two years thereafter, another health assessment must be obtained by all approved Foster Parents.

Health assessment related costs are the responsibility of the Foster Parent Applicants.

The following is the type of general health-related information that a medical practitioner is expected to provide on behalf of the Foster Parent Applicants. A licensed physician must sign all assessments.

| Based on the examination conducted, were any physical/mental health conditions identified that are likely to make it difficult for parenting-related duties to be performed on behalf of children/adolescents referred to their home? | | |
|---|---|---|
| ☐Yes | ☐No | If yes, please explain: _____ |

| Does the examined individual have a communicable disease, which could be spread through casual contact? | | |
|---|---|---|
| ☐Yes | ☐No | If yes, what is the disease?_____ |

| If yes to the above question, explain how this disease could affect how the person would perform duties as a foster parent, or how it could affect the health of children who live in their home. |
|---|
| _____ |

| Provide the date and the results of the most recent Tuberculin Test | | |
|---|---|---|
| Date: | Pos: | Neg: |

****If TB was not deemed necessary to determine the individual is free of communicable disease please date and initial above with "n/a" where results would apply****

Together the Foster Parent Applicants/Foster Parents and their medical practitioner will decide which communicable diseases testing will be conducted.

The signature below is verification that I have examined the above-named individual. The information provided above is an accurate reflection of the examination conducted.

Name of Medical Practitioner: _____

Signature: _____ Date: _____